

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014168</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>03/20/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRAND VALLEY GARDENS ASSISTED LIVING FACILI</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1151 S HUBERT CIRCLE WEST MARTINSVILLE, IN 46151</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey date: March 20, 2025</p> <p>Facility number: 014168</p> <p>Residential Census: 44</p> <p>Grand Valley Gardens Assisted Living Facility was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>Quality review completed March 21, 2025.</p>	R 000		

Indiana Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE